FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022418

Facility Name: Regency Healthcare & Rehab Ctre

Address: 6631 North Milwaukee Avenue (Number) Niles (City) 60714 (Zip Code)

County: Cook

Telephone Number: (847) 647-7444 **Fax #** (847) 588-1330

HFS ID Number: 362871301002

Date of Initial License for Current Owners: 05/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,552	2,782	9,428	20,762	8
9	SNF/PED					9
10	ICF	36,527	19,158		55,685	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,079	21,940	9,428	76,447	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.81%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/13/1976

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/30/1981 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 8,838

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	421,208	44,152	30,559	495,919		495,919		495,919			1
2	Food Purchase		424,644		424,644	(58,035)	366,609	(1,211)	365,398			2
3	Housekeeping	265,833	30,035		295,868		295,868		295,868			3
4	Laundry	117,624	31,247	615	149,486		149,486		149,486			4
5	Heat and Other Utilities			270,396	270,396		270,396	4,051	274,447			5
6	Maintenance	112,929	24,277	64,767	201,973		201,973	3,670	205,643			6
7	Other (specify):*											7
8	**TOTAL General Services**	917,594	554,355	366,337	1,838,286	(58,035)	1,780,251	6,510	1,786,761			8
	B. Health Care and Programs											
9	Medical Director			52,800	52,800		52,800		52,800			9
10	Nursing and Medical Records	3,532,719	103,149	10,516	3,646,384		3,646,384		3,646,384			10
10a	Therapy	45,389	445	12,911	58,745		58,745	47	58,792			10a
11	Activities	168,859	7,204	2,100	178,163		178,163		178,163			11
12	Social Services	250,934			250,934		250,934		250,934			12
13	CNA Training											13
14	Program Transportation							262	262			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,997,901	110,798	78,327	4,187,026		4,187,026	309	4,187,335			16
	C. General Administration											
17	Administrative	182,868		371,000	553,868		553,868	(161,922)	391,946			17
18	Directors Fees											18
19	Professional Services			109,299	109,299	(8,479)	100,820	4,313	105,133			19
20	Dues, Fees, Subscriptions & Promotions			119,356	119,356		119,356	(75,303)	44,053			20
21	Clerical & General Office Expenses	254,554	45,605	159,217	459,376		459,376	(126,387)	332,989			21
22	Employee Benefits & Payroll Taxes			1,085,924	1,085,924	58,035	1,143,959		1,143,959			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,940	2,940		2,940	(60)	2,880			24
25	Other Admin. Staff Transportation			646	646		646		646			25
26	Insurance-Prop.Liab.Malpractice			327,322	327,322		327,322	9,665	336,987			26
27	Other (specify):*							14,876	14,876			27
28	**TOTAL General Administration**	437,422	45,605	2,175,704	2,658,731	49,556	2,708,287	(334,818)	2,373,469			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,352,917	710,758	2,620,368	8,684,043	(8,479)	8,675,564	(327,999)	8,347,565			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Regency Healthcare & Rehab Ctre #0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			91,348	91,348		91,348	199,946	291,294			30
31	Amortization of Pre-Op. & Org.			10,704	10,704		10,704	(10,704)				31
32	Interest			93,327	93,327		93,327	303,696	397,023			32
33	Real Estate Taxes			467,424	467,424	8,479	475,903	23,854	499,757			33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,080,000)				34
35	Rent-Equipment & Vehicles			40,959	40,959		40,959		40,959			35
36	Other (specify):*											36
37	TOTAL Ownership			1,783,762	1,783,762	8,479	1,792,241	(563,208)	1,229,033			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	75,455	406,986	231,840	714,281		714,281	(4,593)	709,688			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*	77,871			77,871		77,871	(77,871)				43
44	TOTAL Special Cost Centers	153,326	406,986	396,090	956,402		956,402	(82,464)	873,938			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,506,243	1,117,744	4,800,220	11,424,207		11,424,207	(973,672)	10,450,535			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	58,957	30		9
10	Interest and Other Investment Income	(10,898)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,211)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(111,883)	21		24
25	Fund Raising, Advertising and Promotional	(14,928)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,066)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(60,270)	20		28
29	Other-Attach Schedule	(102,163)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (249,762)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(723,909)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (723,909)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (973,672)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Regency Healthcare & Rehab Ctre

ID# 0022418

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (71,459)	43	1
2	Bank Charges	(8,741)	21	2
3	Amortization of Loan Acquisition	(10,704)	31	3
4	Non-Care Asset Depreciation	(1,775)	30	4
5	Marketing Salary	(5,812)	43	5
6	1998 Real Estate Tax Refund	(458)	33	6
7	Non-Allowable Seminar	(60)	24	7
8	Marketing Bonus	(600)	43	8
9	Collections	(1,551)	19	9
10	Non-Allowable Legal	(1,803)	19	10
11				11
12				12
13				13
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100				100
101	**Total**	(102,163)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,211)											(1,211)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,603	2,448								4,051	5
6	Maintenance			1,452	2,218								3,670	6
7	Other (specify):*													7
8	**TOTAL General Services**	(1,211)		3,055	4,666								6,510	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy				47								47	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				262								262	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**				309								309	16
	C. General Administration													
17	Administrative					(161,922)							(161,922)	17
18	Directors Fees													18
19	Professional Services	(2,554)		245	2,997	3,625							4,313	19
20	Fees, Subscriptions & Promotions	(75,498)			95	100							(75,303)	20
21	Clerical & General Office Expenses	(127,690)			1,303								(126,387)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(60)											(60)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			703	8,962								9,665	26
27	Other (specify):*					14,876							14,876	27
28	**TOTAL General Administration**	(205,802)		948	13,357	(143,321)							(334,818)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(207,013)		4,003	18,332	(143,321)							(327,999)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Regency Healthcare & Rehab Ctre** **#** **0022418** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	57,182	134,359	3,354	5,051								199,946	30
31	Amortization of Pre-Op. & Org.	(10,704)											(10,704)	31
32	Interest	(10,898)	296,879	6,509	11,206								303,696	32
33	Real Estate Taxes	(458)		9,620	14,692								23,854	33
34	Rent-Facility & Grounds		(1,032,000)	(48,000)									(1,080,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	35,122	(600,762)	(28,517)	30,949								(563,208)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(4,593)								(4,593)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(77,871)											(77,871)	43
44	TOTAL Special Cost Centers	(77,871)			(4,593)								(82,464)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(249,762)	(600,762)	(24,514)	44,688	(143,321)							(973,672)	45

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Kennetih Nieman	33.34	None		Regency Mgmt	Niles	Mgmt Co
Benjamin Rogow	33.33			KNR Partnership	Niles	Building Co
Lother Kahn	33.33			Regency Rehab	Niles	Therapy Co
				Regency Building	Niles	Building Co

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,032,000	Regency Building	100.00%	$	$ (1,032,000)	1
2	V	32	Interest		Regency Building	100.00%	296,879	296,879	2
3	V	30	Depreciation		Regency Building	100.00%	134,359	134,359	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,032,000			$ 431,238	$ * (600,762)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		5	UTILITIES	$	KNR ENTERPRISES	100.00%	$ 1,603	$ 1,603	15
16	V		6	REPAIRS AND MAINT.		KNR ENTERPRISES		1,452	1,452	16
17	V		19	PROFESSIONAL FEES		KNR ENTERPRISES		245	245	17
18	V		20	DUES AND SUBS.		KNR ENTERPRISES				18
19	V		21	CLERICAL		KNR ENTERPRISES				19
20	V		26	INSURANCE		KNR ENTERPRISES		703	703	20
21	V		30	DEPRECIATION		KNR ENTERPRISES		3,047	3,047	21
22	V		32	INTEREST EXPENSE		KNR ENTERPRISES		6,509	6,509	22
23	V		33	REAL ESTATE TAXES		KNR ENTERPRISES		9,620	9,620	23
24	V					KNR ENTERPRISES				24
25	V									25
26	V		34	RENT	48,000	KNR ENTERPRISES			(48,000)	26
27	V									27
28	V									28
29	V		30	DEPRECIATION		KNR ENTERPRISES		307	307	29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 48,000			$ 23,486	$ * (24,514)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	REGENCY REHABILITATION SERVICES, INC.	100.00%	$ 2,448	$ 2,448	15
16	V	6	REPAIRS AND MAINT.		REGENCY REHABILITATION SERVICES, INC.		2,218	2,218	16
17	V	10	NURSING		REGENCY REHABILITATION SERVICES, INC.				17
18	V	10A	THERAPY CONSULTANTS		REGENCY REHABILITATION SERVICES, INC.		47	47	18
19	V	14	PROGRAM TRANSPORTATION		REGENCY REHABILITATION SERVICES, INC.		262	262	19
20	V	19	PROFESSIONAL FEES		REGENCY REHABILITATION SERVICES, INC.		2,997	2,997	20
21	V	20	DUES AND SUBS.		REGENCY REHABILITATION SERVICES, INC.		95	95	21
22	V	21	CLERICAL		REGENCY REHABILITATION SERVICES, INC.		1,303	1,303	22
23	V	26	INSURANCE		REGENCY REHABILITATION SERVICES, INC.		8,962	8,962	23
24	V	30	DEPRECIATION		REGENCY REHABILITATION SERVICES, INC.		5,051	5,051	24
25	V	32	INTEREST EXPENSE		REGENCY REHABILITATION SERVICES, INC.		11,206	11,206	25
26	V	33	REAL ESTATE TAXES		REGENCY REHABILITATION SERVICES, INC.		14,692	14,692	26
27	V	39	THERAPY SALARY & BENEFITS		REGENCY REHABILITATION SERVICES, INC.		59,026	59,026	27
28	V								28
29	V								29
30	V								30
31	V	39	PHYSICAL THERAPY	63,619	REGENCY REHABILITATION SERVICES, INC.			(63,619)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 63,619			$ 108,306	$ * 44,688	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		19	PROFESSIONAL FEES	$	REGENCY MANAGEMENT CORP.	100.00%	$ 3,625	$ 3,625	15
16	V		20	DUES, SUBSCRIPTIONS		REGENCY MANAGEMENT CORP.		100	100	16
17	V					REGENCY MANAGEMENT CORP.				17
18	V									18
19	V		17	MANAGEMENT FEES	371,000	REGENCY MANAGEMENT CORP.			(371,000)	19
20	V									20
21	V									21
22	V		17	ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		77,158	77,158	22
23	V		27	EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		5,490	5,490	23
24	V									24
25	V		17	ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		70,357	70,357	25
26	V		27	EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		5,006	5,006	26
27	V									27
28	V		17	ADMINISTRATIVE		REGENCY MANAGEMENT CORP.		61,563	61,563	28
29	V		27	EMPLOYEE BENEFITS		REGENCY MANAGEMENT CORP.		4,380	4,380	29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 371,000			$ 227,679	$ * (143,321)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Kenneth Neiman	Secretary	Administrative	33.34%	None	10.00	25.00%	Mgmt Fee	$ 61,563	17-7	1
2	Benjamin Rogow	President	Administrative	33.33%	None	47.00	78.33%	Mgmt Fee	77,158	17-7	2
3	Lother Kahn	Treasurer	Administrative	33.33%	None	15.00	37.50%	Mgmt Fee	70,357	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 209,078		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: KNR ENTERPRISES
Street Address: 6625 N MILWAKEE
City / State / Zip Code: NILES, IL 60714
Phone Number: ((847) 647 - 1166
Fax Number: ((847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	SQUARE FOOTAGE	6,654	4	$ 17,312	$	616	$ 1,603	1
2	6	REPAIRS AND MAINT.	SQUARE FOOTAGE	6,654	4	15,688		616	1,452	2
3	19	PROFESSIONAL FEES	SQUARE FOOTAGE	6,654	4	2,650		616	245	3
4	20	DUES AND SUBS.	SQUARE FOOTAGE	6,654	4			616		4
5	21	CLERICAL	SQUARE FOOTAGE	6,654	4			616		5
6	26	INSURANCE	SQUARE FOOTAGE	6,654	4	7,589		616	703	6
7	30	DEPRECIATION	SQUARE FOOTAGE	6,654	4	32,913		616	3,047	7
8	32	INTEREST EXPENSE	SQUARE FOOTAGE	6,654	4	70,311		616	6,509	8
9	33	REAL ESTATE TAXES	SQUARE FOOTAGE	6,654	4	103,911		616	9,620	9
10										10
11										11
12										12
13										13
14										14
15	30	DEPRECIATION	DIRECT ALLOCATION		4	3,086			307	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 253,460	$		$ 23,486	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REGENCY REHAB SERVICES
Street Address: 6625 N MILWAKEE
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647 - 1116
Fax Number: (847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	THERAPY INCOME	67,013	3	$ 2,578	$	63,619	$ 2,448	1
2	6	REPAIRS AND MAINT.	THERAPY INCOME	67,013	3	2,336		63,619	2,218	2
3	10	NURSING	THERAPY INCOME	67,013	3			63,619		3
4	10A	THERAPY CONSULTANTS	THERAPY INCOME	67,013	3	886		63,619	47	4
5	14	PROGRAM TRANSPORTATION	THERAPY INCOME	67,013	3	276		63,619	262	5
6	19	PROFESSIONAL FEES	THERAPY INCOME	67,013	3	3,156		63,619	2,997	6
7	20	DUES AND SUBS.	THERAPY INCOME	67,013	3	100		63,619	95	7
8	21	CLERICAL	THERAPY INCOME	67,013	3	1,373		63,619	1,303	8
9	26	INSURANCE	THERAPY INCOME	67,013	3	9,441		63,619	8,962	9
10	30	DEPRECIATION	THERAPY INCOME	67,013	3	5,321		63,619	5,051	10
11	32	INTEREST EXPENSE	THERAPY INCOME	67,013	3	11,804		63,619	11,206	11
12	33	REAL ESTATE TAXES	THERAPY INCOME	67,013	3	15,476		63,619	14,692	12
13	39	THERAPY SALARY & BENEFIT	THERAPY INCOME	67,013	3	62,174	55,390	63,619	59,026	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 114,921	$ 55,390		$ 108,306	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REGENCY MANAGEMENT CORP
Street Address: 6021 N. LAWNDALE
City / State / Zip Code: CHICAGO IL 60659
Phone Number: (847) 647 - 1116
Fax Number: (847) 588 - 1330

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	MNGMNT. FEE INC.	371,000	2	$ 3,625	$	371,000	$ 3,625	1
2	20	DUES, SUBSCRIPTIONS	MNGMNT. FEE INC.	371,000	2	100		371,000	100	2
3										3
4										4
5										5
6										6
7										7
8	17	ADMINISTRATIVE	AVG. HOURS-ROGOW	60	3	98,500	98,500	47	77,158	8
9	27	EMPLOYEE BENEFITS	AVG. HOURS-ROGOW	60	3	7,008		47	5,490	9
10										10
11	17	ADMINISTRATIVE	AVG. HOURS-KAHN	21	3	98,500	98,500	15	70,357	11
12	27	EMPLOYEE BENEFITS	AVG. HOURS-KAHN	21	3	7,008		15	5,006	12
13										13
14	17	ADMINISTRATIVE	AVG. HOURS-NEIMAN	16	3	98,500	98,500	10	61,563	14
15	27	EMPLOYEE BENEFITS	AVG. HOURS-NEIMAN	16	3	7,008		10	4,380	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 320,249	$ 295,500		$ 227,679	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Regency Nursing Venture		X	Second Mortgage	$19,542.00	5/30/81	$ 2,405,912	$ 76,881	5/1/06	7.7300	$ 15,746	1
2	Northen Life Insurance		X	Mortgage	$64,500.00	3/1/95	6,000,000	2,706,418	3/1/10	10.0000	296,879	2
3	Allocated-Regency Rehab										11,206	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	JP Morgan Chase		X	Line of Credit				870,000			77,581	6
7	Regency at Home Health		X					410,122				7
8	See Supplemental Schedule										6,509	8
9	TOTAL Facility Related				$84,042.00		$ 8,405,912	$ 4,063,421			$ 407,921	9
	B. Non-Facility Related*											
10	Interest Income		X								(10,898)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (10,898)	14
15	TOTALS (line 9+line14)						$ 8,405,912	$ 4,063,421			$ 397,023	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated KNR Enterprises		X				$	$			$ 6,509	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										6,509	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 375,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 446,736	2
3. Under or (over) accrual (line 2 minus line 1).	$ 71,736	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 420,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$ 8,479	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 24,113 For 98, 01 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$ (458)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 499,757	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	394,231	8
2001	389,218	9
2002	394,414	10
2003	424,813	11
2004	422,424	12

Accrual = CY x 1.00
422424 x 1.0 = 420000 (rounded)
Allocated from KNR Enterprises - 9,620
Allocated from Regency Rehab - 14,692

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Healthcare & Rehab Ctre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0022418

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-31-401-017-0000	Long Term Care Property	$ 3,870.18	$ 3,870.18
2.	10-31-401-018-0000	Long Term Care Property	$ 92,790.84	$ 92,790.84
3.	10-31-401-019-0000	Long Term Care Property	$ 116,486.41	$ 116,486.41
4.	10-31-401-020-0000	Long Term Care Property	$ 116,486.41	$ 116,486.41
5.	10-31-401-021-0000	Long Term Care Property	$ 92,790.73	$ 92,790.73
6.	See Attached	See Attached	$ 90,211.21	$ 18,370.45
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 512,635.78	$ 440,795.02

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

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2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Regency Healthcare & Rehab Ctre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0022418

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,591 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Regency At-Home Health Services, Ltd. - Home Health Agency - Separate Building
Regency At-Home Care Service, Ltd. - Home Health and Adult Day Care Agency - Separate Building
Regency Rehabilitation Service, Ltd. - Rehabilitation Company - Separate Building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		4/30/1981	$ 450,000	1
2					2
3	TOTALS			$ 450,000	3

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	2,440		20			1,502	9
10	Various			1995	55,899		20	2,796	2,796	29,593	10
11	Various			1996	143,243		20	7,167	7,167	67,509	11
12	Various			1997	109,626		20	5,484	5,484	47,510	12
13	Various			1998	546,842		20	27,342	27,342	197,716	13
14	Various			1999	142,449		20	7,123	7,123	46,864	14
15	Various			2000	98,866		20	4,945	4,945	28,682	15
16	Various			2001	112,212		20	5,613	5,613	25,937	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		3,708,375	134,359		123,613	(10,746)	1,574,865	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		339,268	8,406		10,098	1,692	114,925	68
69	Financial Statement Depreciation			39,721			(39,721)		69
70	TOTAL (lines 4 thru 69)		$ 5,259,220	$ 182,486		$ 194,181	$ 11,695	$ 2,135,103	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,259,220	$ 182,486		$ 194,181	$ 11,695	$ 2,135,103	1
2	Door-Dialysis Room	2002	1,450		20	145	145	580	2
3	Electrical	2002	7,904		20	790	790	3,030	3
4	Plumbing-Dialysis Room	2002	30,850		20	3,085	3,085	11,826	4
5	Circuit Panelboard	2002	23,500		20	2,350	2,350	8,617	5
6	Dialysis Room	2002	10,550		20	1,055	1,055	3,780	6
7	Drapes	2002	5,952		20	595	595	1,885	7
8	Signs	2002	1,190		20	119	119	446	8
9	Wallcovering	2002	682		20	68	68	250	9
10	Handsink	2002	594		20	59	59	228	10
11	Fountain	2002	2,965		20	297	297	1,013	11
12	Pump Installation	2002	2,950		20	295	295	959	12
13	Modulators	2002	1,890		20	189	189	630	13
14	Electrical Fixtures	2002	1,360		20	136	136	419	14
15	Wallpaper	2003	8,519		20	852	852	2,201	15
16	Closed Circuit Tv System	2003	6,860		20	686	686	1,944	16
17	Landscaping	2003	13,320		20	1,332	1,332	3,552	17
18	Leasehold Improvements	2003	4,748		20	475	475	1,266	18
19	Leasehold Improvements	2003	2,674		20	267	267	691	19
20	Install Delayed Egress System	2003	15,845		20	1,585	1,585	3,961	20
21	Install Door	2003	1,674		20	167	167	391	21
22	Install Keyless Entry System	2003	1,785		20	179	179	417	22
23	Install Keyless Entry System	2003	1,685		20	169	169	365	23
24	Elecrical Improv	2004	15,618		20	1,562	1,562	2,343	24
25	Nurse Call System	2004	18,975		20	1,898	1,898	2,530	25
26	Window Drapes	2004	43,746		20	4,375	4,375	6,562	26
27	Repair Tile	2004	1,812		20	181	181	317	27
28	Phase Failure System	2005	23,400		20	2,340	2,340	2,340	28
29	Handicap Acess Door	2005	6,100		20	508	508	508	29
30	Elevator Equip	2005	4,379		20	511	511	511	30
31	Hot Water Boiler	2005	4,847		20	808	808	808	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
18									18
19									19
20									20
21									21
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,527,044	$ 182,486		$ 221,259	$ 38,773	$ 2,199,473	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	300		1981	1976	$ 3,708,375	$ 134,359		$ 123,613	$ (10,746)	$ 1,574,865	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,708,375	$ 134,359		$ 123,613	$ (10,746)	$ 1,574,865	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	KNR Enterprises		1994	1994	$ 118,831	$ 3,047		$ 3,395	$ 348	$ 37,630	4
5	Regency Rehab		1994	1994	181,491	4,654		5,185	531	57,473	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from Regency Rehabilitation			1994	3,697		20			3,697	9
10	Allocated from Regency Rehabilitation			1995	547		10			547	10
11	Allocated from Regency Rehabilitation			1995	8,355	215	20	418	203	4,387	11
12	Allocated from Regency Rehabilitation			1996	2,520		20	126	(126)	1,167	12
13	Allocated from Regency Rehabilitation			1997	147		20	8	8	65	13
14	Allocated from Regency Rehabilitation			1999	2,787	71	20	140	69	907	14
15	Allocated from Regency Rehabilitation			2000	2,314	59	20	116	57	636	15
16	Allocated from Regency Rehabilitation			2003	2,082	53	20	103	50	269	16
17											17
18	Allocated from KNR Enterprises			1994	2,421		20			2,421	18
19	Allocated from KNR Enterprises			1995	358		20			358	19
20	Allocated from KNR Enterprises			1995	5,490	141	20	275	134	2,885	20
21	Allocated from KNR Enterprises			1996	1,657			83	83	767	21
22	Allocated from KNR Enterprises			1997	97			5	5	42	22
23	Allocated from KNR Enterprises			1999	1,833	47		92	45	597	23
24	Allocated from KNR Enterprises			2000	3,272	84		84		900	24
25	Allocated from KNR Enterprises			2003	1,369	35		68	33	177	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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61									61
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63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 339,268	$ 8,406		$ 10,098	$ 1,440	$ 114,925	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 940,368	$ 30,339	$ 67,347	$ 37,008	10	$ 711,237	71
72	Current Year Purchases	21,386	19,512	2,688	(16,824)	10	2,688	72
73	Fully Depreciated Assets	535,732				10	535,732	73
74								74
75	TOTALS	$ 1,497,486	$ 49,851	$ 70,035	$ 20,184		$ 1,249,657	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,474,530	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 232,337	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 291,294	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 58,957	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,449,130	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BUS - 1995	$ 44,625	$ 1,775	$ 20,318	86
87	1996 DODGE CARAVAN - 1996	36,356			87
88					88
89					89
90					90
91	TOTALS	$ 80,981	$ 1,775	$ 20,318	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 40,959 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 99,428	$		$ 99,428	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			16,742			16,742	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	75,455		115,670			191,125	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				288,276		288,276	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						118,710		118,710	13
14	TOTAL			$ 75,455		$ 231,840	$ 406,986		$ 714,281	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre **#** 0022418 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 28,014	$ 28,014	1
2	Cash-Patient Deposits	56,769	56,769	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,079,930	2,079,930	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	327,257	327,257	6
7	Other Prepaid Expenses	1,592	1,592	7
8	Accounts Receivable (owners or related parties)	324,638	324,638	8
9	Other(specify): See Attached Schedule	119,288	119,288	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,937,488	$ 2,937,488	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		760,000	13
14	Buildings, at Historical Cost		5,240,000	14
15	Leasehold Improvements, at Historical Cost	1,339,748	1,339,748	15
16	Equipment, at Historical Cost	1,761,236	1,761,236	16
17	Accumulated Depreciation (book methods)	(1,960,248)	(3,303,838)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	45,511	45,511	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,186,247	$ 5,842,657	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,123,735	$ 8,780,145	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,185,080	$ 2,185,080	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,599	55,599	28
29	Short-Term Notes Payable	1,280,121	1,280,121	29
30	Accrued Salaries Payable	113,896	113,896	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,135	13,135	31
32	Accrued Real Estate Taxes(Sch.IX-B)	420,000	420,000	32
33	Accrued Interest Payable	22,553	22,553	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,800	6,800	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	391,628	391,628	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,488,812	$ 4,488,812	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	76,882	2,783,300	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 76,882	$ 2,783,300	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,565,694	$ 7,272,112	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (441,959)	$ 1,508,033	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,123,735	$ 8,780,145	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Regency Healthcare & Rehab Ctre **#** 0022418 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (632,333)	1
2	Restatements (describe):		2
3	**Rounding**	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (632,330)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	445,371	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(255,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 190,371	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (441,959)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,759,724	1
2	Discounts and Allowances for all Levels	(1,204,141)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,555,583	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	858,961	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 858,961	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	750	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,962	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,370	19
20	Radiology and X-Ray		20
21	Other Medical Services	371,412	21
22	Laundry	3,529	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 420,023	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,898	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,898	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	24,113	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,113	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,869,578	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,838,286	31
32	Health Care	4,187,026	32
33	General Administration	2,658,731	33
	B. Capital Expense		
34	Ownership	1,783,762	34
	C. Ancillary Expense		
35	Special Cost Centers	792,152	35
36	Provider Participation Fee	164,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,424,207	40
41	**Income before Income Taxes (line 30 minus line 40)****	445,371	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 445,371	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,963	2,208	$ 94,948	$ 43.00	1
2	Assistant Director of Nursing	1,879	2,139	74,013	34.60	2
3	Registered Nurses	48,274	51,996	1,320,801	25.40	3
4	Licensed Practical Nurses	15,498	16,944	365,042	21.54	4
5	CNAs & Orderlies	156,610	168,438	1,677,915	9.96	5
6	CNA Trainees					6
7	Licensed Therapist	1,781	2,046	75,455	36.88	7
8	Rehab/Therapy Aides	3,564	4,117	45,389	11.02	8
9	Activity Director	1,951	2,256	37,009	16.40	9
10	Activity Assistants	12,039	13,169	131,850	10.01	10
11	Social Service Workers	15,970	17,580	250,934	14.27	11
12	Dietician	1,825	2,134	55,270	25.90	12
13	Food Service Supervisor	1,813	2,086	36,914	17.70	13
14	Head Cook	5,622	6,117	69,479	11.36	14
15	Cook Helpers/Assistants	32,433	35,045	259,545	7.41	15
16	Dishwashers					16
17	Maintenance Workers	4,911	5,155	112,929	21.91	17
18	Housekeepers	27,414	30,131	265,833	8.82	18
19	Laundry	14,850	16,288	117,624	7.22	19
20	Administrator	1,753	2,045	137,366	67.17	20
21	Assistant Administrator	1,807	2,080	45,502	21.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,745	9,954	254,554	25.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,876	4,352	77,871	17.89	33
34	TOTAL (lines 1 - 33)	364,578	396,280	$ 5,506,243 *	$ 13.89	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	728	$ 30,559	01-03	35
36	Medical Director	Monthly	52,800	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	70	3,475	10-03	38
39	Pharmacist Consultant	Monthly	2,817	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	287	12,911	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,100	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,126	$ 108,886		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Hecht	Administrator	0	$ 137,366
Carol Eaton	Asst. Admin	0	45,502
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 182,868

B. Administrative - Other

Description	Amount
Regency Management Corp-Management Fees	$ 371,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 371,000

C. Professional Services

Vendor/Payee	Type	Amount
Giftrap	Computer	$ 3,540
HDSI	Data Processing	7,910
Sugar, Friedberg & Felsenthal	Legal	1,003
Schmidt Salzman & Moran	Legal-RE Tax Refund	8,479
Winston & Strawn	Legal	3,623
TALX UC Express	Unemployment Consultant	2,835
FR&R	Accounting	54,225
Adjusted Off Page 5	Collections	1,551
KBC Computer	Computer	5,592
Maemar PC	Computer	7,250
Purchase Pluc	Purchase Consultant	550
See Supplemental Schedule		12,741
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 109,299

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 115,107
Unemployment Compensation Insurance	58,983
FICA Taxes	414,109
Employee Health Insurance	401,485
Employee Meals	58,035
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	1,734
Pension Expense	87,156
Holiday Expense	7,350
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,143,959

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	16,150
Health Care Worker Background Check	
(Indicate # of checks performed 151)	1,204
Dues and Subscriptions	742
Dues ICLTC	17,100
Licenses and Fees	6,672
Alloc-Regency Mgmt	100
Alloc-Regency Rehab	95
Advertising and Promotional	75,198
Less: Public Relations Expense	( )
Non-allowable advertising	(14,928)
Yellow page advertising	(60,270)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,053

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,880
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,880

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Regency Healthcare & Rehab Ctre # 0022418 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC-$17,100**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,823** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **164,250**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **58,035** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.